Witness Statement Ref. No. 079/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: Dr Norman Morrow

Title: *Chief Pharmaceutical Officer*

Present position and department/employer:

Chief Pharmaceutical Officer

Department of Health, Social Services and Public Safety

Length of time in post: *9 years, 10 months*

Previous position and department/employer in 1995:

Senior Principal Pharmaceutical Officer

Department of Health, Social Services and Public Safety

Previous position and department/employer in 2000:

As current position

Previous position and department/employer in 2001:

As current position

Membership of Professionals Bodies:

Fellow of the Pharmaceutical Society of Northern Ireland

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

I do not recall how I came to know about any or all of the children's deaths. Certainly, I was aware of Lucy's death as it was specifically raised at the Board meeting on 27th February 2004. I was also in receipt of the hyponatraemia guidelines shortly after their publication in 2002.

ii) Describe in detail the steps you took:
(1) to discover why the children died;
(2) why the DHSSPS was not made aware of the deaths at an earlier stage; and
(3) to ensure that lessons would be learned for the future.

I have not been directly involved in relation to investigations allied to these cases.

(iii) Give details of your colleagues within the DHSSPS with whom you discussed the steps to be taken in response to the deaths of Adam, Lucy and Raychel to include the reasons why and when they were contacted by you and the outcome of your discussions.

The only input I was asked for in relation to hyponatraemia-related deaths was in response to a PQ from Iris Robinson relative to improving knowledge of intravenous fluid management (005-013-077). I advised on the current provision within the undergraduate course at the School of Pharmacy, QUB

[Correspondence submitted ref. 074-039-162]

Particular areas of interest (Cont'd)

(iv) Describe in detail the steps you took to obtain advice from colleagues both within Northern Ireland and outside in respect of the use of solution no. 18, to include with whom you consulted and the advice you were given.

Please refer to response to question (iii).

(v) Describe you role in the formulation of the Departmental guidance issued in 2002 in Hyponatraemia in Children.

I was not involved nor any member of my staff.

(vi) In your role as a member of the Departmental Board, explain what information you received or solicited about the procedures, investigations and events that followed the deaths of Adam, Lucy and Raychel.

I was not privy to the detailed information regarding these cases but the Board was aware of action being taken by other business areas ie..reference in Board Corporate Business 27th February 2004(004-019-236) and Board Meeting of 28th May 2004 (004-020-238).

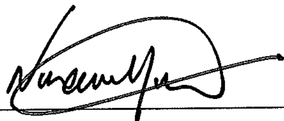
(vii) Again in your role as a member of the Departmental Board, explain what steps you took to discover why the children died and to ensure that any lessons would be learned.

As indicated, while I have not been involved in these cases, I have been actively involved in work contributing to improving safety in the HPSS, specifically focussed upon the safe use of medicines. In this regard we have established a Medicines Governance Team where the emphasis is on a systems approach to minimising the risk of adverse incidents due to medication.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports

[Please attach additional sheets if more space is required]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: 

Dated: 29/7/05